Implementation of personalisation within long term care in Norway and Britain – does it make any difference?

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- Presentation based on earlier research based knowledge about long-term care
  - in Norway (e.g. Christensen 1998, 2005, 2012)
  - In the UK (e.g. Pilling 1992)
  - And comparatively (Christensen 2009, 2010)

➢ And available research and statistics on personalisation in Norway and the UK

Theoretical framework

The idea of: IN-DEPEN-ENCE	Within long-term care services this means a focus on changing the role of users: From PASSIVE recipients to ACTIVE citizens.
	Different welfare states - different kinds of independence: **Nordic model**: independence of family and market **Liberal model**: relies on development of a market
By the end of the 20th century high status	The universal discussion of how to encourage individual freedom: **Democracy discourse:** based on the Independent Living ideology, focus on rights and social inclusion **Market discourse:** based on the idea of the customer role with few restrictions regarding access to a market

‘Personalisation’ in Norway and UK

- «Personalising» services means tailoring services to individuals (instead of fitting individuals to services)
- Most ‘personalised’ welfare variant: cash-for-care giving people influence on who is doing the care work, what is done, when and where
- More British than Norwegian

Norway:
User controlled personal assistance (BPA)
-
Stressing CONTROL

UK:
Direct Payments
Individual budgets
Personal budgets
-
Stressing PAYMENTS/BUDGETS

“Degrees” of personalisation

After the assessment of needs:

BPA: User controlled personal assistance (N)	Personal budgets	Direct payments (DP)	Individual budgets
-Alone -Support-organisation -Municipality	The user takes the personal budget as Direct Payments Or let the council commission the services	The user employs personal assistants him/herself with or without support from an organisation	Same as DP but the budget includes more than social care (different funding streams)

Social care context: Norway and UK

- Norway: Ageing population
- UK: Ageing population, but facing challenges earlier

OECD report: *Public and private expenditure on long-term care as a percentage of GDP, 2000:*

	Total expenditure	Total public expenditure		Total private expenditure	
		Home Care	Institutions	Home Care	Institutions
Norway	2,15	0,66	1,19	0,03	0,26
UK	1,37	0,32	0,58	0,09	0,38

Norway:
Little self-funding
Needs tested services

UK:
Much self-funding
Needs- and means tested services

Public–private (for–profit) distribution

NORWAY:

Less than 10% of long-term care institutions are private (including for-profit and non-profit institutions)

Home care: 12% (Bergen)

UK:

88% of nursing homes and 69% of residential homes run by for-profit sector, 22% by non-profit sector, 1-7% LA

73% of home care agencies provided by for-profit sector, 14% not-profit, 11% LA

Public/private: 90/10	Public/private: 10/90

Important change in public role

The "make sure" role:

- Stressed in the preparation paper for new 2012 Health and care act:
- The municipalities are responsible for providing services but not necessarily themselves

The "enabling" role:

- Sir Roy Griffiths commissioned by Margaret Thatcher to review how public funds are used for community care services:
- "It is vital that social services authorities should see themselves as the arrangers and purchasers of care services – not as monopolistic providers" (Griffiths 1988:5)

Norway

UK

Important structural change

Purchaser

Provider

- Contracting external providers including for-profit companies
- Creating a social care market
- Developing competition between public and private providers
- Market discourse idea: competition will imply more value for money and widen the choices of services meeting peoples' needs

What is happening on the individual level?

- LAs'/municipalities' role regarding assessing needs and arranging packages of care more vital
- The assessment process undergoes more regulation in N and UK

Cash-for-care variations

- Legalised in 2000
- Increasing numbers
- No right to BPA
- The municipalities decide whether a user can get BPA

Norway
Paternalistic

- Legalised in 1996
- Increasing numbers but now in particular of managed budgets
- Right to cash-for-care, the user can choose cash-for-care

UK
Rights based – the user chooses

Different employer roles

- A majority of BPA users are not employing their personal assistants themselves

  54% municipalities
  33% Uloba (cooperative)
  11% user him-herself
  2% private companies
  (Johansen et al. 2010)

- Uloba users experience most influence and get more hours
- Only support organisation contracted by municipalities

- Personal assistants often directly employed by user
- More positive outcome among those with direct payments than those with managed budgets (Hatton and Waters 2011)
- Many and different support organisations: self-reported as non-profit, 2/3 contract with LA, less than 1/3 were employment agencies (Davey et al. 2007)

N	UK
Homogenous	Heterogeneous

Older people as a vulnerable group

Only 8.7% of BPA user 67+ (Statistics Norway)

- No research on this group, but a study (Lie 2011) about older peoples' choices of home care provider shows strategies like these:
- *Distancing* (no capacity to make a decision)
- *Personification* (choosing persons not providers)

29% of older people on PB compared e.g. with 41% of working-age adults with learning disability (Info.Centre 2011)

Research also found challenges: older people with IB did not feel more control (Glendinning et al. 2008):
-explanations: assessments done at a crisis point, responsibility for budget experienced as a burden

Most important for older people: continuity of care fitting in with the person's routine (Sykes & Groom 2011)

N | **UK**

Conclusions

- Both Norway and UK have clearly encouraged a make sure/enabling role for the LAs
- But: the market discourse in terms of mixed economy is much stronger in the UK than in Norway (mirrored in the 90/10, 10/90 distribution producing very different contexts)
- Norwegian municipalities are contracting (mainly) only one organisation, the user-led Uloba while the UK has developed a highly heterogeneous system (most are non-profit, but there are great variations)

- The UK recipe of successful personalisation is more choice and control by including more providers, but this may produce disadvantaged groups (older people)
- The Norwegian system shows that control of the services is not dependent on a choice of providers but on having a suitable provider committed to social inclusion